

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07868		
Item 18 Film 219-8-16-57										Reg. Dist. No. 290		
6774 MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>57 hrs 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg 05x12</u>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>RD</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Phyllis</u> Middle <u>Marian</u> Last <u>Andrews</u>					4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1957</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>January 27-1926</u>		9. AGE (In years last birthday) <u>31</u> yrs.				
								IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Button Sorter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Md Plastic Co</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Alphus Andrews</u>					14. MOTHER'S MAIDEN NAME <u>Mary M Magness</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>218-20-8125</u>			17. INFORMANT <u>Mrs Mary M Andrews (Mother)</u> Address <u>216 Keyf Circle, Federalsburg, Md</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver necrosis</u> <u>580X</u> DUE TO (b) <u>(etiology undetermined)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE <u>L. M. J. Harty</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED		
EXAMINER'S NAME (Type) <u>WELTY</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					6-25-57		
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify)			22b. DATE THEREOF <u>6-27-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lk. Order Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Liverchester Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Hympston</u>					ADDRESS <u>Federalsburg Md</u>		24a. REC'D BY REGISTRAR DATE <u>7/8/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Newkiss</u>			

RECEIVED

JUL 10 1957

BUREAU V. S.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF EXAMINER: [illegible]
DATE: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6775

CERTIFICATE OF DEATH

06757

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>29 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>C.</u> Last <u>Baggs</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1870</u>		9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Andrew Baggs</u>				14. MOTHER'S MAIDEN NAME <u>Susan Kirby</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Walton Willis Denton</u>		Address <u>(Denton Rd.)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334x</u> DUE TO <u>Apoplexy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, generalized</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>450.0</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>5/13</u> , 19 <u>57</u> , to <u>6/11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/11</u> , 19 <u>57</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>P. E. Coy</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Md.</u>			
DATE SIGNED _____							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6/15/57</u>		<u>Greensboro</u>		<u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulaie</u>				ADDRESS <u>Greensboro Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/15/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Newkirk</u>			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. MARRIAGE DATE		8. MARRIAGE PLACE		9. DECEASED DATE		10. DECEASED PLACE	
11. OCCUPATION		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESS		17. SIGNATURE OF DECEASED		18. SIGNATURE OF NEXT OF KIN		19. SIGNATURE OF CLERK		20. SIGNATURE OF JUDGE	
21. SIGNATURE OF DECEASED		22. SIGNATURE OF NEXT OF KIN		23. SIGNATURE OF CLERK		24. SIGNATURE OF JUDGE		25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERK		28. SIGNATURE OF JUDGE		29. SIGNATURE OF DECEASED		30. SIGNATURE OF NEXT OF KIN	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF NEXT OF KIN		33. SIGNATURE OF CLERK		34. SIGNATURE OF JUDGE		35. SIGNATURE OF DECEASED		36. SIGNATURE OF NEXT OF KIN		37. SIGNATURE OF CLERK		38. SIGNATURE OF JUDGE		39. SIGNATURE OF DECEASED		40. SIGNATURE OF NEXT OF KIN	
41. SIGNATURE OF DECEASED		42. SIGNATURE OF NEXT OF KIN		43. SIGNATURE OF CLERK		44. SIGNATURE OF JUDGE		45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF CLERK		48. SIGNATURE OF JUDGE		49. SIGNATURE OF DECEASED		50. SIGNATURE OF NEXT OF KIN	
51. SIGNATURE OF DECEASED		52. SIGNATURE OF NEXT OF KIN		53. SIGNATURE OF CLERK		54. SIGNATURE OF JUDGE		55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN		57. SIGNATURE OF CLERK		58. SIGNATURE OF JUDGE		59. SIGNATURE OF DECEASED		60. SIGNATURE OF NEXT OF KIN	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF NEXT OF KIN		63. SIGNATURE OF CLERK		64. SIGNATURE OF JUDGE		65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERK		68. SIGNATURE OF JUDGE		69. SIGNATURE OF DECEASED		70. SIGNATURE OF NEXT OF KIN	
71. SIGNATURE OF DECEASED		72. SIGNATURE OF NEXT OF KIN		73. SIGNATURE OF CLERK		74. SIGNATURE OF JUDGE		75. SIGNATURE OF DECEASED		76. SIGNATURE OF NEXT OF KIN		77. SIGNATURE OF CLERK		78. SIGNATURE OF JUDGE		79. SIGNATURE OF DECEASED		80. SIGNATURE OF NEXT OF KIN	
81. SIGNATURE OF DECEASED		82. SIGNATURE OF NEXT OF KIN		83. SIGNATURE OF CLERK		84. SIGNATURE OF JUDGE		85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF CLERK		88. SIGNATURE OF JUDGE		89. SIGNATURE OF DECEASED		90. SIGNATURE OF NEXT OF KIN	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF NEXT OF KIN		93. SIGNATURE OF CLERK		94. SIGNATURE OF JUDGE		95. SIGNATURE OF DECEASED		96. SIGNATURE OF NEXT OF KIN		97. SIGNATURE OF CLERK		98. SIGNATURE OF JUDGE		99. SIGNATURE OF DECEASED		100. SIGNATURE OF NEXT OF KIN	

BUREAU V. E.

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06758

6776

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN IB <u>28 da</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edith</u> Middle <u>C</u> Last <u>Barnes</u>				4. DATE OF DEATH Month <u>6</u> Day <u>21</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 10 1906</u>	
9. AGE (In years lost birthday) yrs. <u>50</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETAIL STORES</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Mr Albert D. Carroll</u>			
14. MOTHER'S MARRIAGE NAME <u>Eliza H. Grissin</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Mr Walter S. Barnes (husb)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of cervix</u> <u>171X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis to lungs</u> DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <u>18 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> to <u>June</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 21</u> , 19 <u>57</u> , and that death occurred at <u>Easton Md</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>W. Hampton Carroll</u> M.D. <u>Easton Md</u>				PHYSICIAN'S NAME (Type) <u>W. Hampton Carroll</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/24/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Carroll</u> ADDRESS <u>EASTON MD.</u>				24a. REC'D BY REGISTRAR DATE <u>6/24/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	

RECEIVED

6794

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06759

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY TALBOT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WYTRAPPE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE N.J. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CAMDEN 67X-3 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) VIRGINIA JANE Fooks BESSEY First Middle Last 4. DATE OF DEATH Month 6 Day 29 Year 1957		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-30-29 9. AGE (In years last birthday) 27 yrs. IF UNDER 1 YEAR: Months 27 Days 27 Hours 27 Min. 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RCA 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Geo. HERBERT Fooks 14. MOTHER'S MAIDEN NAME VIOLA SKIPPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 850x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from a motor launch (over) 20c. TIME OF INJURY Month, Day, Year 6/29/57 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) WYTRAPPE 20f. (City or town) (County) (State) TALBOT MD		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>	
ACTUAL SIGNATURE Louise M. Kelly EXAMINER'S NAME (Type) WELTY 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF 7/3/57 22c. NAME OF CEMETERY OR CREMATORY Rebelleman Memorial Park 22d. LOCATION (City, town, or county) (State) Easton Md. R.D.		DATE SIGNED 6-29-57 M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Conell ADDRESS EASTON, MD 24a. REC'D BY REGISTRAR 7/1/57 24b. REGISTRAR'S SIGNATURE N.A. Newey			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

20^b

.... from Evening Sun, 7/1/57.

BUREAU V. S.

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06760			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 290			
1. PLACE OF DEATH a. COUNTY <u>Talbot</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>48X-3</u>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>					c. LENGTH OF STAY IN 1b <u>13 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>48X-3</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>					d. STREET ADDRESS <u>747 W. Orange Lakeside Blvd</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Bradley</u> Last <u>Bradley</u>					4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1957</u>								
5. SEX <u>M</u>		6. COLOR OR RACE <u>Co</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>?</u>				
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Unknown</u>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>					16. SOCIAL SECURITY NO. <u>263-26-5525</u>		17. INFORMANT <u> </u> Address <u> </u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hemorrhage</u> <u>983X</u> DUE TO <u>Blow on skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>?</u> a. m. <u>6-16?</u> p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Lewis M. Welty</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>6-18-57</u>			
EXAMINER'S NAME (Type) <u>WELTY</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u> </u>			22b. DATE THEREOF <u>6/17/57</u>			22c. NAME OF CEMETERY OR CREMATORY <u>Cathy Morgan</u>			22d. LOCATION (City, town or county) (State) <u>Baltimore Md</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leon St. Henry</u>					ADDRESS <u>2416 N. 1st St</u>		24a. REC'D BY REGISTRAR <u> </u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Newen</u>				
					DATE <u>6/19/57</u>								

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

JUN 28 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6778

CERTIFICATE OF DEATH

06761

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>63 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				d. STREET ADDRESS <u>Queenstown, 17x22</u>			
3. NAME OF DECEASED (Type or print) First <u>ETTA</u> Middle <u>G</u> Last <u>Brittingham</u>				4. DATE OF DEATH Month <u>6</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 25, 1907</u>	9. AGE (In years last birthday) <u>49</u> yrs.	10. IF UNDER 1 YEAR Months <u>6</u> Days <u>13</u> Hours <u>57</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. A.</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>William GRAYSON</u>				14. MOTHER'S MAIDEN NAME <u>Della PARSONS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>2195 Washington St</u>			
17. INFORMANT <u>Linda W. Brittingham, husband - same</u>				Address <u>Easton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Infiltrating Carcinoma of Stomach</u> 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Due to</u> (c) <u>Stomach</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>a. 11</u> Month <u>19</u> Day <u>19</u> Year <u>1957</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u>				(County) <u>Queen Anne</u> (State) <u>Md.</u>			
21. I certify that I attended the deceased from <u>1957</u> , to <u>June 8, 1957</u> , that I last saw the deceased alive on <u>June 8, 1957</u> , and that death occurred at <u>7:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>2195 Washington St, Easton, Md.</u>			
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>				DATE SIGNED <u>June 8, 1957</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>June 11, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Old Burial</u>		22d. LOCATION (City, town, or county) <u>Easton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Barton Brothers, Centerville, Md.</u>				24a. REC'D BY REGISTRAR <u>6/11/57</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Neuman</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—Baltimore 13

RECEIVED

6795

CERTIFICATE OF DEATH

06762
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HOME - Rolle's Lane</u>				d. STREET ADDRESS <u>1 Rolle's Lane</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>ISAIAH</u> Middle <u>BROOKS</u> Last <u>BROOKS</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>22</u> Year <u>1957</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 4, 1873</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>		IF UNDER 24 HRS. Months <u>83</u> Days <u>83</u> Hours <u>83</u> Min. <u>83</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN & FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Talbot Cty. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOSEPH BROOKS</u>				14. MOTHER'S MAIDEN NAME <u>SARAH J. McQUAY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>THELMA JONES - St. Michaels, Md.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenocarcinoma tongue & throat</u> 199.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cokephic generalized, severe</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>9-30</u> , 19 <u>55</u> , to <u>6-22</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6-22</u> , 19 <u>57</u> , and that death occurred at <u>2 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry M. Reeser Jr.</u>				ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>6-24-57</u>			
PHYSICIAN'S NAME (Type) <u>Harry M. Reeser Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JUNE 25, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EASTON Colored</u>		22d. LOCATION (City, town, or county) <u>EASTON</u> (State) <u>MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall - St. Michaels</u>				24. REG'D BY REGISTRAR <u>JUN 27 1957</u> 24b. REGISTRAR'S SIGNATURE <u>H. F. Adnich</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

BUREAU V. 5

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6779

CERTIFICATE OF DEATH

06763

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Talbot b. COUNTY Easton			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS Rt 4 Box 55			
e. IS RESIDENCE ON FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) May First R. Middle Brooks Last				4. DATE OF DEATH Month 6 Day 12 Year 57			
5. SEX Female		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/31/87	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife				10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Mar yland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PERRY BROOKS				14. MOTHER'S MAIDEN NAME MARY ELIA JENKINS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) XXXX		16. SOCIAL SECURITY NO. XXXXXXXXXX		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart disease 420.0 DUE TO (b) Generalized Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Arteriosclerosis 334X 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 57 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State) None	
21. I certify that I attended the deceased from 1-24 , 19 55 , to 6-12 , 19 57 , that I last saw the deceased alive on 6-12 , 19 57 , and that death occurred at 8:30 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) EASTON, Md. DATE SIGNED 6/13/57 ACTUAL SIGNATURE William L. Winters M.D. PHYSICIAN'S NAME (Type) WILLIAM L. WINTERS EASTON, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/15/57		22c. NAME OF CEMETERY OR CREMATORY Wellesley Ave		22d. LOCATION (City, town, or county) (State) Boston Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Clark ADDRESS Easton, Md.				24a. REC'D BY REGISTRAR JUN 24 1957		24b. REGISTRAR'S SIGNATURE N. H. Reeves	

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
John Doe		Male		45		1/1/20		Baltimore		Maryland		U.S.A.			
OCCUPATION		EDUCATION		MARRIAGE		DATE OF MARRIAGE		NAME OF SPOUSE		DATE OF DEATH		PLACE OF DEATH		CITY	
Teacher		High School		Married		1945		Jane Doe		1/15/20		Baltimore		Maryland	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY		STATE		COUNTRY	
Heart Disease		Natural		Physician		1/15/20		Baltimore		Maryland		U.S.A.			
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JUN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

6780

06764

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>1 hr 25 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro, MS</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>Brooks</u> Last <u>Brooks</u>				4. DATE OF DEATH Month <u>June</u> Day <u>9</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>December 1, 1923</u>		9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John W. Brooks</u>					
14. MOTHER'S MAIDEN NAME <u>Catherine Hollowell</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Floyd Wothers</u> Address <u>Drummersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Fractures - Internal Organs</u> DUE TO (b) <u>Auto Accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Collision of Automobiles</u>					
20c. TIME OF INJURY Month, Day, Year <u>6/9 1957</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>			
20f. (City or town) <u>Easton, Md.</u>		(County) <u>Caroline</u>		(State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Lauron O. George</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Lauron O. George</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>6-10-57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/13/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>			
22d. LOCATION (City, town, or county) <u>Greensboro</u>		(State) <u>Md.</u>		24a. REC'D BY REGISTRAR <u>N.H. Newlin</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulaire</u>		ADDRESS <u>Greensboro, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newlin</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH—SACRAMENTO, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06765

CERTIFICATE OF DEATH

Reg. Dist. No.

6796

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>			c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>EAST CHESTNUT ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>D.</u> Last <u>CAULK</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>30</u> Year <u>1957</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 2 1870</u>		
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>COMMERCIAL SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>DAWSON CAULK</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET DONOPHON</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>James Caulk, Syracuse New York</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>uremia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma prostate c</u> DUE TO (c) <u>metastases</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular, advanced</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>422.1</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>3-27</u> , 195 <u>7</u> , to <u>6-30-57</u> , that I last saw the deceased alive on <u>6-30-57</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michaels md</u> DATE SIGNED <u>7-1-57</u>								
ACTUAL SIGNATURE <u>Wm M. Reeser Jr</u> M.D.				PHYSICIAN'S NAME (Type) <u>Wm M. Reeser Jr</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burned</u>		22b. DATE THEREOF <u>July 2, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Christ Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hamilton Harrison</u> ADDRESS <u>St. Michaels md</u>				24a. REC'D BY REGISTRAR DATE <u>Jul 5 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Reese</u>		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 6781
 CERTIFICATE OF DEATH

06766
 Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>1a120+</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>E</u> Last <u>Cooper</u>				4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1880</u>	9. AGE (In years lost birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATERMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles E. Cooper</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Hazelton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>219037547A</u>			
17. INFORMANT <u>William Cooper, Chester</u>				Address <u>2011 Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis - left hemiplegia</u> <u>022x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic heart disease</u> DUE TO (c) <u>Ischemic heart disease due to (b) - cardiac infarct</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>(?)</u> <u>(?)</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/29</u> , 19 <u>57</u> , to <u>6/15</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>15 June</u> , 19 <u>57</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Thurston Harrison</u>				ADDRESS (Street, city or town, state) <u>Easton, Maryland</u>			
M.D. <u> </u>				DATE SIGNED <u> </u>			
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/18/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Back Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Grassonsville, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Butler</u>				ADDRESS <u>Bethesda, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/18/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>N.H. Newell</u>			

JUN 24 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6782

CERTIFICATE OF DEATH

06767

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>26 da.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED First <u>James</u> Middle <u>Cornish</u> Last <u>Cornish</u>		4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Cornish</u>		14. MOTHER'S MAIDEN NAME <u>Mary Viney</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary V. Cornish (wife)</u> Address <u>June</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) <u>yes</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>430.0</u> <u>Gangrene left leg due to thrombosis of common iliac artery 2 wks.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>19</u> , 19 <u>53</u> , to <u>June 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>June 11</u> , 19 <u>57</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>6/12/57</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Sheena A. KRECH</u> M.D.			
PHYSICIAN'S NAME (Type) <u>S. KRECH</u> M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/14/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Unionville</u>	22d. LOCATION (City, town, or county) (State) <u>Easton, Md R 1</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Orkell</u> ADDRESS <u>Easton, Md</u>		24a. REC'D BY REGISTRAR DATE <u>6/14/57</u>	24b. REGISTRAR'S SIGNATURE <u>N. H. Nevins</u>

CERTIFICATE OF DEATH

NAME OF DECEASED <i>James Earl Ray</i>		DATE OF BIRTH <i>Jan 24 1928</i>		PLACE OF BIRTH <i>London, England</i>	
MARRIAGE <i>Married</i>		OCCUPATION <i>Writer</i>		EDUCATION <i>High School</i>	
DATE OF DEATH <i>June 19 1967</i>		PLACE OF DEATH <i>London, England</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Heart Disease</i>		TREATMENT <i>None</i>	
SIGNATURE OF DECEASED <i>James Earl Ray</i>		SIGNATURE OF WITNESS <i>James Earl Ray</i>		SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>	
DATE OF SIGNATURE <i>June 19 1967</i>		DATE OF SIGNATURE <i>June 19 1967</i>		DATE OF SIGNATURE <i>June 19 1967</i>	
PLACE OF SIGNATURE <i>London, England</i>		PLACE OF SIGNATURE <i>London, England</i>		PLACE OF SIGNATURE <i>London, England</i>	
DATE OF DEATH <i>June 19 1967</i>		PLACE OF DEATH <i>London, England</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Heart Disease</i>		TREATMENT <i>None</i>	
SIGNATURE OF DECEASED <i>James Earl Ray</i>		SIGNATURE OF WITNESS <i>James Earl Ray</i>		SIGNATURE OF PHYSICIAN <i>James Earl Ray</i>	
DATE OF SIGNATURE <i>June 19 1967</i>		DATE OF SIGNATURE <i>June 19 1967</i>		DATE OF SIGNATURE <i>June 19 1967</i>	
PLACE OF SIGNATURE <i>London, England</i>		PLACE OF SIGNATURE <i>London, England</i>		PLACE OF SIGNATURE <i>London, England</i>	

BUREAU V. S.

JUN 19 1967

RECEIVED

James Earl Ray

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg</u>			
c. LENGTH OF STAY IN 1b <u>20 days</u>				d. STREET ADDRESS <u>Silveto St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wancy</u> Middle <u>N.</u> Last <u>Govey</u>				f. DATE OF DEATH Month <u>6</u> Day <u>10</u> Year <u>1957</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 9-1880</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Nichols</u>		14. MOTHER'S MAIDEN NAME <u>Emily Edgell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Va. C. Eluck - daughter - same</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral aneurysm of the anterior c.</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>unknown</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5/22</u> , 19 <u>57</u> , to <u>6/10</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>6/10</u> , 19 <u>57</u> , and that death occurred at <u>11:30</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Thurston Harrison</u> M.D.							
PHYSICIAN'S NAME (Type) <u>THURSTON HARRISON M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>June 13, 1957</u>		<u>Belmont Cemetery</u>		<u>Federalburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry Williams</u> ADDRESS <u>Federalburg, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>6/13-57</u>		24b. REGISTRAR'S SIGNATURE <u>N.A. Neer</u>	

CERTIFICATE OF DEATH

BUREAU V. 81

JUN 18 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6784

CERTIFICATE OF DEATH

06769

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wye Mills 17x12</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>P.</u> Last <u>Denny</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1912</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Benjamin Somers</u>				14. MOTHER'S MAIDEN NAME <u>Salome Garey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Walter Denny Street Wye Mills Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-cranial hemorrhage</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive cardio-vascular disease</u> DUE TO <u>Nephrosclerosis</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1957</u> to <u>1957</u> , that I last saw the deceased alive on <u>October 1, 1957</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>2195 Washington St. Easton 16, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				DATE SIGNED <u>June 57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 3-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>talbot Co Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. A. Beckler</u> ADDRESS <u>101 W. Main St. Easton Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>6-3-57</u>		24b. REGISTRAR'S SIGNATURE <u>M.H. Neekie</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

11 1957

RECEIVED

6797

CERTIFICATE OF DEATH

067770

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Easton</u>		c. LENGTH OF STAY IN 1b <u>50 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>x Rural Easton</u>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth Thomas Wright Dixon</u>		4. DATE OF DEATH <u>June 8 1957</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Joseph Ten Brunen Wright</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Amelia Kennard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>W. H. Norris</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> <u>Yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9/11, 1950</u> , to <u>6/10, 1957</u> , that I last saw the deceased alive on <u>6/6, 1957</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Shepherd</u> M.D.		ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>6/10/57</u>	
PHYSICIAN'S NAME (Type) <u>Shepherd Kreech, Jr.</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>June 10</u>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <u>Armory Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Clark</u> ADDRESS <u>Easton</u>		24. REC'D BY REGISTRAR <u>W. H. Norris</u> 24b. REGISTRAR'S SIGNATURE <u>W. H. Norris</u>	

1 **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUN 13 1957

RECEIVED

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06771

6785

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Queen Anne's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville, Md.	
c. LENGTH OF STAY IN 1b 2 days		d. STREET ADDRESS 17x22	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertie Middle Louise Last Robson		4. DATE OF DEATH Month 6 Day 26 Year 1957	
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1882
9. AGE (In years and birth day) 74 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not known		14. MOTHER'S MAIDEN NAME Rosie Rich	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic heart disease (c) (?)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 715x Chronic hypotension - etc.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 24, 1957 , to June 26, 1957 , that I last saw the deceased alive on June 26, 1957 , and that death occurred at 2:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Thurston Harrison M.D. Centreville, Maryland DATE SIGNED 28 June 57			
PHYSICIAN'S NAME (Type) THURSTON HARRISON			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF June 29, 1957	22c. NAME OF CEMETERY OR CREMATORY Centreville Cemetery	22d. LOCATION (City, town, or county) (State) Centreville Maryland
23. FUNERAL DIRECTOR'S SIGNATURE James H. Butler of Butler Bros., Centreville, Md.		24a. REC'D BY REGISTRAR 6/29/57	24b. REGISTRAR'S SIGNATURE N. H. Neff

BUREAU V. S.

JUL 1 1957

RECEIVED

6798

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Shickles</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Ridgely</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>NATHANIEL HARRY GANNON</u>		4. DATE OF DEATH <u>JUNE 27 1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 8, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NATHANIEL GANNON</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE KATRUP</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ED W. GANNON, EASTON, MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>420.1</u> DUE TO <u>arteriosclerotic coronary heart d</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerosis - diffuse - generalized</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-19-57</u> to <u>6-27-57</u> , that I last saw the deceased alive on <u>6-27-57</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michaels Md</u> DATE SIGNED <u>6-27-57</u>			
ACTUAL SIGNATURE <u>Guy M. Reeser</u>		M.D. <u>St Michaels Md</u>	
PHYSICIAN'S NAME (Type) <u>Guy M. Reeser</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>JULY 1, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL</u>	22d. LOCATION (City, town, or county) (State) <u>EASTON, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Virgil Moorehead</u>		ADDRESS <u>Denton, Md.</u>	
24a. REC'D BY REGISTRAR <u>7/1/57</u>		24b. REGISTRAR'S SIGNATURE <u>M. H. Reeser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES	
RACE		COLOR		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		MILITARY SERVICE		REMARKS	
WHITE		WHITE		METHODIST		MARRIED		HIGH SCHOOL		LABORER		ARMY		DIED OF HEART DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL	
JUL 6 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		JUL 8 1968		MOBILE		ALABAMA	
NAME OF PHYSICIAN		NAME OF SURGEON		NAME OF PATHOLOGIST		NAME OF MORTUARY		NAME OF FUNERAL HOME		NAME OF BURIAL PLACE		NAME OF CEMETERY		NAME OF CHURCH	
DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		DR. JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF SURGEON		SIGNATURE OF PATHOLOGIST		SIGNATURE OF MORTUARY		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF CHURCH	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		CITY OF CERTIFICATE		STATE OF CERTIFICATE		COUNTRY OF CERTIFICATE		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
JUL 8 1968		MOBILE, ALABAMA		MOBILE		ALABAMA		UNITED STATES		JUL 6 1968		MOBILE		ALABAMA	

BUREAU V. 2

JUL 8 1967

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6799

CERTIFICATE OF DEATH

06773

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>NEAVITT</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEAVITT</u>				c. LENGTH OF STAY IN 1b <u>15</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>LENA</u> Middle <u>S.</u> Last <u>GITH</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>8</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV 29 1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARTINSBURG, W. VA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JOHN MATHEWS</u>				14. MOTHER'S MAIDEN NAME <u>IDA GALLAGHER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>		17. INFORMANT <u>JOHN GITH, NEAVITT, MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>adenomatosis - generalized</u> <u>153X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>adenocarcinoma colon</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>cochexia - severe</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 1952</u> to <u>June 8, 1957</u> , that I last saw the deceased alive on <u>June 8, 1957</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>St Michael's Md</u> DATE SIGNED <u>6-9-57</u>							
ACTUAL SIGNATURE <u>Guy M Beeser Jr</u> M.D.				DATE SIGNED <u>6-9-57</u>			
PHYSICIAN'S NAME (Type) <u>Guy M Beeser Jr</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-10-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Hamilton Harrison</u>				ADDRESS <u>St. Michael's</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u> </u> DATE <u>JUN 11 '57</u>	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH BALTIMORE, MD		DATE OF DEATH 1957	
NAME OF DECEASED JOHN MARION		SEX Male	
AGE 15		RACE White	
PLACE OF BIRTH Baltimore, Md		DATE OF BIRTH 1942	
OCCUPATION Student		CAUSE OF DEATH (To be filled by physician)	
PLACE OF DEATH Home		DATE OF DEATH 1957	
NAME OF PHYSICIAN Dr. J. H. Smith		SIGNATURE OF PHYSICIAN (To be filled by physician)	
NAME OF FUNERAL HOME (To be filled by funeral home)		SIGNATURE OF FUNERAL HOME (To be filled by funeral home)	
NAME OF NEXT OF KIN (To be filled by next of kin)		SIGNATURE OF NEXT OF KIN (To be filled by next of kin)	
NAME OF CORONER (To be filled by coroner)		SIGNATURE OF CORONER (To be filled by coroner)	
NAME OF REGISTRAR (To be filled by registrar)		SIGNATURE OF REGISTRAR (To be filled by registrar)	

BUREAU V. 1

JUN 11 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

6786

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06774

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>1 hr 15 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X1 Trappe, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hospital</u>			d. STREET ADDRESS <u>1 Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LARRY</u> First <u>GREEN</u> Middle <u>GREEN</u> Last			4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-10-49</u>	9. AGE (In years last birthday) <u>8</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School child</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Wilbur H. Green</u>			14. MOTHER'S MAIDEN NAME <u>Emma Jones</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Wilbur Green, father - same</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra-ventricular cerebral</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hemorrhage</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Louis M. Wietz</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-3-57</u>	
EXAMINER'S NAME (Type) <u>WIELT</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/4/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trappe Cem.</u>	
22d. LOCATION (City, town, or county) <u>Trappe</u>		(State) <u>Md.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u> ADDRESS <u>Easton, Md.</u>	
24a. REC'D BY REGISTRAR <u>6-4-57</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. Neer</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination and death certification, including fields for name, date, time, place, and cause of death. The form is mostly blank with some faint markings.

RECEIVED
JUN 11 1957
BUREAU V. 5

6787

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			c. LENGTH OF STAY IN 1b <u>7 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Cordova</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hosp.</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u></u> Last <u>Harris</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>m</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>70</u> yrs.	
9. AGE (In years last birthday) <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Chicken Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Harris</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Dobson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT (Name) <u>Minnie Cooper</u> Address <u>200 Glenwood Ave., Easton.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X</u> DUE TO <u>Pneumonia - Med. failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>retained obstruction by</u> DUE TO <u>Cancer of urinary bladder</u> (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. <u>1</u> p. m. Month <u>19</u> Day <u>19</u> Year <u>1957</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Easton</u> (County) <u></u> (State) <u>MD</u>				21. I certify that I attended the deceased from <u>PM</u> , 19 <u>57</u> , to <u>1957</u> , that I last saw the deceased alive on <u>1957</u> , and that death occurred at <u>8:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Welch</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Md.</u>		DATE SIGNED <u>6-12-57</u>	
PHYSICIAN'S NAME (Type) <u>WELCH</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/15/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Welch</u>				ADDRESS <u>Easton Md.</u>		24a. REC'D BY REGISTRAR DATE <u>6/15/57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Neekens</u>			

BUREAU V. 8

1957 61 NOV

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06776

6788

CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>13 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Goldsboro 05x12</u>			
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>J</u> Last <u>Heller</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 20, 1900</u>		9. AGE (In years last birthday) <u>36</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Heller</u>				14. MOTHER'S MAIDEN NAME <u>Emma Schlechtweg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Helen Heller</u> Address <u>White</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic nephron nephrosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>20 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent surgical partial gastrectomy.</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. 11</u> Month <u>June</u> Day <u>10</u> Year <u>1957</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>June 10, 1957</u> to <u>June 11, 1957</u> , that I last saw the deceased alive on <u>June 11, 1957</u> , and that death occurred at <u>8:12 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert D. Solomon</u> M.D.				ADDRESS (Street, city or town, state) <u>3204 Duchester Rd Bto.</u> DATE SIGNED <u>6/11/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert D. Solomon, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/12/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Silverbrook</u>		22d. LOCATION (City, town, or county) <u>Brenton</u> (State) <u>N.J.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Boulsis</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR <u>N. A. Newkirk</u> DATE <u>6/12/57</u>		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. PLACE OF DEATH		10. DATE OF DEATH		11. TIME OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. PLACE OF INTERMENT		18. DATE OF INTERMENT		19. TIME OF INTERMENT		20. CAUSE OF INTERMENT		21. MANNER OF INTERMENT		22. SIGNATURE OF INTERMENT OFFICIAL		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF WITNESSES	
25. PLACE OF BURIAL		26. DATE OF BURIAL		27. TIME OF BURIAL		28. CAUSE OF BURIAL		29. MANNER OF BURIAL		30. SIGNATURE OF BURIAL OFFICIAL		31. SIGNATURE OF REGISTRAR		32. SIGNATURE OF WITNESSES	
33. PLACE OF CREMATION		34. DATE OF CREMATION		35. TIME OF CREMATION		36. CAUSE OF CREMATION		37. MANNER OF CREMATION		38. SIGNATURE OF CREMATION OFFICIAL		39. SIGNATURE OF REGISTRAR		40. SIGNATURE OF WITNESSES	
41. PLACE OF EXHUMATION		42. DATE OF EXHUMATION		43. TIME OF EXHUMATION		44. CAUSE OF EXHUMATION		45. MANNER OF EXHUMATION		46. SIGNATURE OF EXHUMATION OFFICIAL		47. SIGNATURE OF REGISTRAR		48. SIGNATURE OF WITNESSES	
49. PLACE OF REINTERMENT		50. DATE OF REINTERMENT		51. TIME OF REINTERMENT		52. CAUSE OF REINTERMENT		53. MANNER OF REINTERMENT		54. SIGNATURE OF REINTERMENT OFFICIAL		55. SIGNATURE OF REGISTRAR		56. SIGNATURE OF WITNESSES	
57. PLACE OF REINTERMENT		58. DATE OF REINTERMENT		59. TIME OF REINTERMENT		60. CAUSE OF REINTERMENT		61. MANNER OF REINTERMENT		62. SIGNATURE OF REINTERMENT OFFICIAL		63. SIGNATURE OF REGISTRAR		64. SIGNATURE OF WITNESSES	
65. PLACE OF REINTERMENT		66. DATE OF REINTERMENT		67. TIME OF REINTERMENT		68. CAUSE OF REINTERMENT		69. MANNER OF REINTERMENT		70. SIGNATURE OF REINTERMENT OFFICIAL		71. SIGNATURE OF REGISTRAR		72. SIGNATURE OF WITNESSES	
73. PLACE OF REINTERMENT		74. DATE OF REINTERMENT		75. TIME OF REINTERMENT		76. CAUSE OF REINTERMENT		77. MANNER OF REINTERMENT		78. SIGNATURE OF REINTERMENT OFFICIAL		79. SIGNATURE OF REGISTRAR		80. SIGNATURE OF WITNESSES	
81. PLACE OF REINTERMENT		82. DATE OF REINTERMENT		83. TIME OF REINTERMENT		84. CAUSE OF REINTERMENT		85. MANNER OF REINTERMENT		86. SIGNATURE OF REINTERMENT OFFICIAL		87. SIGNATURE OF REGISTRAR		88. SIGNATURE OF WITNESSES	
89. PLACE OF REINTERMENT		90. DATE OF REINTERMENT		91. TIME OF REINTERMENT		92. CAUSE OF REINTERMENT		93. MANNER OF REINTERMENT		94. SIGNATURE OF REINTERMENT OFFICIAL		95. SIGNATURE OF REGISTRAR		96. SIGNATURE OF WITNESSES	
97. PLACE OF REINTERMENT		98. DATE OF REINTERMENT		99. TIME OF REINTERMENT		100. CAUSE OF REINTERMENT		101. MANNER OF REINTERMENT		102. SIGNATURE OF REINTERMENT OFFICIAL		103. SIGNATURE OF REGISTRAR		104. SIGNATURE OF WITNESSES	

BUREAU V. S.

JUN 18 1957

RECEIVED

6800

CERTIFICATE OF DEATH

06777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. LENGTH OF STAY IN 1b <u>FEW MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 RIO VISTA NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MALVINA</u> Middle <u>P.</u> Last <u>LANDON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>23</u> Year <u>1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 1 - 1868</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>WM H. PARKS</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>HOWARD LANDON</u>		Address <u>SHERWOOD, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Dis</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 wk.</u> <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>331X</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>June</u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>22 March, 1956</u> , to <u>23 June, 1957</u> , that I last saw the deceased alive on <u>22 June, 1957</u> , and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Kneale Wright</u>				DATE SIGNED <u>6-24-57</u>			
PHYSICIAN'S NAME (Type) <u> </u>				M.D. <u>Box 487, St. Michaels, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SHERWOOD</u>		22d. LOCATION (City, town, or county) (State) <u>SHERWOOD MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Norman D. Marshall - St. Michaels</u>				24. RECORD BY REGISTRAR <u>JUN 27 1957</u>			
25. REGISTRAR'S SIGNATURE <u> </u>				26. REGISTRAR'S SIGNATURE <u> </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

JUN 27 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

Reg. Dist. No. 296

6801

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe, Md.		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Trappe d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle DENNY Last MARSHALL		4. DATE OF DEATH Month June Day 3 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 16, 1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farmer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Elijah Marshall		14. MOTHER'S MAIDEN NAME Annie E. Satchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 220-28-0837	
17. INFORMANT Mrs. J. Alberta Marshall		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Carcinoma, Occult Bleeding			INTERVAL BETWEEN ONSET AND DEATH yes
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-1-1957 to June 3, 1957 , that I last saw the deceased alive on June 2, 1957 , and that death occurred at 8:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE M. F. Buell		ADDRESS (Street, city or town, state) Easton, Md.	
PHYSICIAN'S NAME (Type) Dr. Martin F. Buell		DATE SIGNED 6-4-57	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 5, 1957	22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery	22d. LOCATION (City, town, or county) (State) Easton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR DATE 6-5-57		24b. REGISTRAR'S SIGNATURE M. H. Neekies	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2.0

BUREAU V. S.

JUN 11 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

290

6802

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First ARCHIE Middle MARVEL Last		4. DATE OF DEATH Month June Day 27 Year 19 57	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1897
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tavern owner		10b. KIND OF BUSINESS OR INDUSTRY Tavern owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Thomas Marvel		14. MOTHER'S MAIDEN NAME Elizabeth McMeal	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-01-8254	
17. INFORMANT Thomas Marvel		Address Trappe, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 1954 to 6/27/1957 , that I last saw the deceased alive on 6/25/1957 , and that death occurred at 10:45 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Dr. P. Evans Cox		M.D. Easton, Md.	
22a. BURIAL, CREMATION, REMAINS (Specify) Burial		22b. DATE THEREOF June 29, 1957	
22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery		22d. LOCATION (City, town, or county) (State) Easton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Maurice E. Newnam & Son		ADDRESS Easton, Md.	
24a. REC'D BY REGISTRAR 6/29/57		24b. REGISTRAR'S SIGNATURE N.A. Neenan	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar's name, burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. 8

1957 8

6803

CERTIFICATE OF DEATH

06780

Reg. Dist. No.

290

1. PLACE OF DEATH o. COUNTY TALBOT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY TALBOT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - EASTON				c. LENGTH OF STAY IN 1b 50 YRS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "OAKLANDS"				d. STREET ADDRESS 1 "OAKLANDS"			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First SALLIE Middle ANN Last MARVEL				4. DATE OF DEATH Month JUNE Day 15 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 22, 1874	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME SAMUEL THOMAS				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. EDGAR SLAUGHTER, EASTON, R.D. MD. Address "OAKLANDS"	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis (c) (?)				INTERVAL BETWEEN ONSET AND DEATH 3 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 334X				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 1957 , to 15 June 1957 , that I last saw the deceased alive on 15 June 1957 , and that death occurred at M , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED 17 June 57			
ACTUAL SIGNATURE Thurston Harrison M.D.							
PHYSICIAN'S NAME (Type) THURSTON HARRISON							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORY SPRING HILL CEMETERY		22d. LOCATION (City, town, or county) (State) EASTON MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE W. Hampton Burt ADDRESS EASTON, MD.				24a. REC'D BY REGISTRAR DATE JUN 21 1957		24b. REGISTRAR'S SIGNATURE N. H. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JUN 21 1957

RECEIVED

0678190

6804
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bozman				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bozman			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) Frederick Sidney Meyer				4. DATE OF DEATH Month June Day 14 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16, 1866		9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Jerusalem Church of New		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME Metzger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. H. Paul Kernen - Glen Eagle Point, Bozman			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO 6 mon (c) Generalized Atherosclerosis DUE TO 15 yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 450.0				INTERVAL BETWEEN ONSET AND DEATH 12 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4 Dec 1956 to 14 June 1957 , that I last saw the deceased alive on 6/1/57 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. Paul Kernen				ADDRESS (Street, city or town, state) Box 487, St. Michaels, Md. DATE SIGNED 6-14-57			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/17/57		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tickner & Sons - Balt.				24a. REC'D BY REGISTRAR W. A. Nevins		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for burial, cremation, or removal, and in any event within 72 hours after death.

JUN 18 1957

BUREAU V. S.

JUN 18 1957

CERTIFICATE OF DEATH

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Trappe				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Mary Morris Mills				4. DATE OF DEATH Month Day Year 6 18 1957			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1873	9. AGE (In years last birthday) 84 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) xxx		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) xxxx		17. INFORMANT Address Elsie Wright, Trappa, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May 18, 1957 to June 18, 1957 , that I last saw the deceased alive on May 18, 1957 , and that death occurred at MD M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hayward T. Hill				ADDRESS (Street, city or town, state) 1331 North Eastern, Md.			
PHYSICIAN'S NAME (Type) M.D.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/57		22c. NAME OF CEMETERY OR CREMATORY Mills Family Cen.		22d. LOCATION (City, town, or county) (State) Trappe, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell, Easton, Md				24a. REC'D BY REGISTRAR JUN 25 1957		24b. REGISTRAR'S SIGNATURE N. A. Kowis	

ANALYSTS STATE DEPARTMENT OF HEALTH—BALTIMORE 18

Handwritten text, likely a signature or name, appearing as "H. R. Thompson" or similar.

1957 25 JUN

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06784

6789

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely 05 x 02</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W</u> Last <u>Sculley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1878</u>	
9. AGE (In years lost birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Donald Watson (Daughter)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis, right</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Old cerebral infarcts.</u> DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> o. <u> </u> p. <u> </u> Month <u> </u> Day <u> </u> Year <u> 19 </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>2/20/1915</u> , 19 <u> </u> , to <u> </u> , 19 <u> </u> , that I last saw the deceased alive on <u>2/20/1915</u> , 19 <u> </u> , and that death occurred at <u>4:06 P.</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>				ADDRESS (Street, city or town, state) <u>Easton 16, Maryland.</u>			
M.D. <u>219 S. West 117 St. 19 June 57</u>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 22/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DENTON</u>		22d. LOCATION (City, town, or county) (State) <u>DENTON MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. V. McCrete & Son</u>				ADDRESS <u>DENTON</u>		24a. REC'D BY REGISTRAR DATE <u>6/22/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>M. R. Neenan</u>	

MAINE STATE DEPARTMENT OF HEALTH—SALMONELLA 15

BUREAU V. S.

JUN 27 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6790

CERTIFICATE OF DEATH

06785

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oxford, xo	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle SPARKLIN Last SPARKLIN			4. DATE OF DEATH Month JUNE Day 30 Year 1957				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 30, 1865		9. AGE (In years last birthday) 92 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mr Joseph Lowery				14. MOTHER'S MAIDEN NAME Mary Gavigton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr Thomas Sparklin Hospital Records (Son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Unkndle 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Biliary cirrhosis DUE TO (c) Carcinoma of pancreas							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 5810							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 5:32 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. C. H. Schmidt				ADDRESS (Street, city or town, state) DATE SIGNED 219 S. Washington ST. 1 Oct 57			
PHYSICIAN'S NAME (Type) E. C. H. Schmidt				Easton, 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-3-57		22c. NAME OF CEMETERY OR CREMATORY Oxford Cemetery		22d. LOCATION (City, town, or county) (State) Oxford, md	
23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison, St Michael's				ADDRESS md.		24a. REC'D BY REGISTRAR DATE 7/3/57	
				24b. REGISTRAR'S SIGNATURE W. H. Newlin			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED	
16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CHURCH		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

BUREAU V. A.

JUL 8 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06786

Reg. Dist. No.

290

6806

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MD. b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak.				c. LENGTH OF STAY IN lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 145				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Royal Oak			
f. STREET ADDRESS Box 145				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles Henry Thomas				4. DATE OF DEATH Month Day Year 6 17 19 57			
5. SEX Male		6. COLOR OR RACE col.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/5/15	
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.s.a.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY Domestic			
13. FATHER'S NAME Joseph A. Thomas				14. MOTHER'S MAIDEN NAME Vesta Wallace			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) XXXXXX				16. SOCIAL SECURITY NO. XXXXXXXX			
17. INFORMANT Vesta Jenkins				Address Royal Oak			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental drowning 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) drowned while swimming			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 6-17 19 e8:30p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Tred Avon River at Bellvue Wharf Talbot MD	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Louis S. Welty				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Louis S. Welty				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 6-18-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/20/57		22c. NAME OF CEMETERY OR CREMATORY Royal cem.		22d. LOCATION (City, town, or county) (State) Royal Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James B. Dashiell				ADDRESS Easton Md.		24a. REC'D BY REGISTRAR JUN 24 1957	
				24b. REGISTRAR'S SIGNATURE N. H. Hervey			

STATE DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1957

BUREAU V. 3

JUN 24 1957

RECEIVED

Item 18 Film 218 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8-8-57 ams 6791 Item 6 Film 217 6-26-57 et
CERTIFICATE OF DEATH

06787

Reg. Dist. No.

290

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Talbot			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 Port				d. STREET ADDRESS 1 21 Port			
3. NAME OF DECEASED (Type or print) First Middle Last William T. Tilghman				4. DATE OF DEATH Month Day Year 6 13 1957			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1989	9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Janitor		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Tilghman				14. MOTHER'S MAIDEN NAME Laura Matthews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Martha Mitchell Easton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Pending lab report by Dr. W. C. Corcoran, Jr.							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 6-9 , 19 57 , to 6-13 , 19 57 , that I last saw the deceased alive on 6-12 , 19 57 , and that death occurred at 12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE W. F. Buell M.D.				ADDRESS (Street, city or town, state) Easton Md		DATE SIGNED 6-15-57	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/18/57		22c. NAME OF CEMETERY OR CREMATORY Richards Cem.		22d. LOCATION (City, town, or county) (State) Easton Md	
23. FUNERAL DIRECTOR'S SIGNATURE James McNeill				ADDRESS Easton, Md		24a. REC'D BY REGISTRAR 24 1957	
				24b. REGISTRAR'S SIGNATURE H. H. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 77 hours after death.

CERTIFICATE OF DEATH

NAME		JAMES M. WATSON	
AGE		67	
SEX		Male	
RACE		Caucasian	
DATE OF BIRTH		June 1, 1890	
PLACE OF BIRTH		Baltimore, Md.	
OCCUPATION		Laborer	
CAUSE OF DEATH		Heart Disease	
DATE OF DEATH		June 1, 1957	
PLACE OF DEATH		Home	
SIGNATURE OF DECEASED			
SIGNATURE OF WITNESSES			
SIGNATURE OF PHYSICIAN			
SIGNATURE OF CLERK			
SIGNATURE OF REGISTRAR			
SIGNATURE OF JUDGE			
SIGNATURE OF SHERIFF			
SIGNATURE OF CORONER			
SIGNATURE OF DISTRICT ATTORNEY			
SIGNATURE OF COUNTY CLERK			
SIGNATURE OF CITY CLERK			
SIGNATURE OF VICE MAYOR			
SIGNATURE OF MAYOR			

BUREAU V. S.

JUN 24 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06788		
Item 21 Film 217 6721-57 ans										6792		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 290		
1. PLACE OF DEATH a. COUNTY TALBOT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY TALBOT							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON				c. LENGTH OF STAY IN 1b 5 min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO CORDOVA						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL					d. STREET ADDRESS 1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last WARNER					4. DATE OF DEATH Month JUNE Day 9 Year 1957							
5. SEX ma le		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-26-39		9. AGE (In years last birthday) 18 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Le on Warner					14. MOTHER'S MAIDEN NAME Helen Kellum							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]				16. SOCIAL SECURITY NO.		17. INFORMANT Berinece Clayton			Address Cordova Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Contact GSW rt chest-shotgun 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. 6-9-57 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Cordova Talbot Md				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .												
ACTUAL SIGNATURE Louis S. We lty					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 6-9-57				
EXAMINER'S NAME (Type) Louis S. We lty					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 6/2/57		22c. NAME OF CEMETERY OR CREMATORY Newtown		22d. LOCATION (City, town, or county) (State) Cordova RD Md				
23. FUNERAL DIRECTOR'S SIGNATURE James B. Washburn Easton						ADDRESS		24a. REC'D BY REGISTRAR 6/2/57		24b. REGISTRAR'S SIGNATURE N.H. Neer		

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JUN 19 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6793

CERTIFICATE OF DEATH

06790

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> 2 1/2 hrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Easton</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>			d. STREET ADDRESS <u>1209 Goldsboro St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>W. Tyler Wrightson</u>			4. DATE OF DEATH <u>June 7 1957</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27 1918</u> 38 yrs.		9. AGE (In years last birthday) <u>38</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CANNER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Frances H. Wrightson</u>		
14. MOTHER'S MAIDEN NAME <u>Marian Tyler</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>W. W. II</u>		
16. SOCIAL SECURITY NO. <u>218-059141</u>			17. INFORMANT <u>Mrs. Geraldine Wrightson</u> (Same)		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Essential Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u> <u>5 yrs</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>1946</u> to <u>6/7</u> 19 <u>57</u> , that I last saw the deceased alive on <u>6/7</u> 19 <u>57</u> , and that death occurred at <u>1:42</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>133 Cor</u> DATE SIGNED <u>San Antonio</u> ACTUAL SIGNATURE <u>San Antonio</u> M.D. <u>San Antonio</u> PHYSICIAN'S NAME (Type) _____					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>June 10, 57</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	
22d. LOCATION (City, town, or county) <u>Easton</u>		22e. STATE <u>Md</u>		22f. REG. BY REGISTRAR <u>W. H. Neer</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Neer</u>		23a. ADDRESS <u>Easton</u>		23b. REGISTRAR'S SIGNATURE <u>W. H. Neer</u>	

